PRESCRIPTION FORM FOR PASTEURIZED DONOR HUMAN MILK (PDHM)

***Healthcare providers**: Fax or email prescription to Human Milk Repository of New Mexico*
Fax: 505-508-5428 **Email:** info@mothersmilkbanknm.org

BABY'S NAME: ____________________________________ **DOB:** ___________________ **GA:**____________

Today's date: _____________

Please provide _________oz/day amounts of PDHM for ________ days/weeks/months (circle one) for the following reasons:

- ❏ Z39.1 Encounter for lactation
- ❏ 07.32 Prematurity
- ❏ O92.3 Agalactia
- ❏ O92.4 Hypogalactia
- ❏ O92.5 Low Milk Supply/ Suppressed Lactation
- ❏ O92.7 Unspecified disorders of lactation
- ❏ Z02.82 Adopted Child
- ❏ O30.0 Twin Pregnancy
- ❏ O30.1 Triplet Pregnancy
- ❏ P92.0 Vomiting of newborn
- ❏ P92.1 Regurgitation and rumination of newborn
- ❏ P92.2 Slow feeding of newborn
- ❏ P92.3 Underfeeding of newborn
- ❏ P92.5 Neonatal difficulty in feeding at breast
- ❏ P92.6 Failure to thrive in newborn
- ❏ P92.8 Other feeding problems of newborn
- ❏ P92.9 Feeding problem of newborn, unspecified
- ❏ P59.9 Hyperbilirubinemia
- ❏ P70.4 Hypoglycemia
- ❏ Q383.1 Frenulum Restriction
- ❏ Other:___________________________

Healthcare provider:

Signature: ____

Name: ____

NPI#____

Phone number: ____

Practice Name or Hospital: ____

Address: ____

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Parents/Guardians:

Name: ____

Address: ____

Phone: ____

Email: ____

Providers: Please contact us if you need help determining the appropriate amount to prescribe
Parents/Guardians: To set up an account to order milk, contact us at 505-508-5291 or orders@mothersmilkbanknm.org